DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Medical Assistance Administration
Olympia Washington

To: CUP Women Providers
Managed Care Plans
Regional Administrators
CSO Administrators

Memorandum No.: 03-10 MAA
Issued: May 5, 2003

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration

Subject: Clarification of Revenue and Diagnosis Codes Used to Bill MAA for CUP Women Services

The purpose of this memorandum is to provide replacement pages for MAA's Chemical-Using Pregnant (CUP) Women Billing Instructions. The replacement pages contain clarification about the daily room and board revenue code and the primary and secondary ICD-9-CM diagnosis codes providers must use to bill MAA for CUP Women services.

What has changed?

- **Effective for admissions on and after June 1, 2003**, MAA will discontinue using state-unique revenue code 168 for daily room and board and begin using revenue code 129.

- MAA has modified the list of ICD-9-CM diagnosis codes that providers must use to bill MAA for CUP Women services as follows:

  a) Primary diagnosis

     i. **648.33** (drug dependency – antepartum);
     ii. **648.34** (drug dependency – postpartum);
     iii. **648.43** (for alcohol dependency – antepartum); or
     iv. **648.44** (for alcohol dependency – postpartum).

  b) Secondary diagnosis

     i. **304 - 304.93** (drug dependency); or
     ii. **303 - 303.93** (for alcohol dependency).

- MAA added the following to the description of form locator 22 "Patient Status" on page F.2 of the UB-92 Claim Form Instructions: "08 = Discharged/transferred to home care of a Home IV provider."

To obtain this memorandum or replacement pages E.1-E.4 and F.1-F.8 for MAA's Chemical-Using Pregnant (CUP) Women Billing Instructions electronically, go to MAA's website at http://maa.dshs.wa.gov (click on Provider Publications/Fee Schedules). The replacement pages include billing information and claim form instructions using the current ICD-9-CM diagnosis codes.

Billing

How do I bill for CUP Women services?

Use the UB-92 claim form to bill the hospital-based, intensive CUP Women services provided to the client. Follow these guidelines when billing:

1. In order to facilitate processing of claims under this program, MAA has established a daily room and board revenue code. This revenue code is 129. Use this revenue code for the entire CUP stay. You must indicate this revenue code in form locator 51 of the UB-92. MAA reimburses for daily room rate charges with this revenue code only.

> ☞ **Note:** For stays that exceed 26 days, bill:
>
> - Hardcopy by attaching a copy of the MAA written approval for extended stay with the claim;
> - Electronically by entering the date of approval and dates of service approved in the ***Remarks*** Field.

2. All claims for CUP Women services **must** have a primary diagnosis code related to pregnancy and a secondary diagnosis code related to alcohol or drug abuse. When billing MAA for CUP Women services, you must use the appropriate diagnosis codes from the following list of ICD-9-CM diagnosis codes:

   a) Primary diagnosis

      i. 648.33 (drug dependency – antepartum);
      ii. 648.34 (drug dependency – postpartum);
      iii. 648.43 (for alcohol dependency – antepartum); or
      iv. 648.44 (for alcohol dependency – postpartum).

   b) Secondary diagnosis

      i. 304 through 304.93 (drug dependency); or
      ii. 303 through 303.93 (alcohol dependency).

3. For all other (ancillary) revenue codes, refer to MAA's Inpatient Hospital Billing Instructions.

4. When billing:

   a) Direct Entry - Request an ***S*** batch (inpatient non-DRG) when calling the Claims Control Unit at (360) 725-1950 for batch activation.
   b) Electronically - CUP Women services must be entered as follows:

      RECORD TYPE: 10
      RECORD NAME: Provider Data
      FIELD NUMBER: 2

      Indicate the type of batch equivalent to an ***S*** batch (inpatient non-DRG).

5. When inpatient hospital acute detoxification and medical stabilization services are 24 hours or less, you must bill these services as a short stay on an outpatient claim.

   Inpatient hospitals must use their regular provider number and follow MAA's Inpatient Hospital Billing Instructions to bill non-DRG claims. *Do not* use the provider number issued for three-day or five-day detoxification programs, as these are different programs and funded through the county.

   MAA reimburses the hospital a percentage of ***allowed charges*** for these services. CUP Women services are exempt from DRG reimbursement methodology. Reimbursement is based on the hospital's ratio of cost-to-charges (RCC) rate and usual and customary fee.

How do I bill for physician/ARNP services?

Physicians, physician's assistants-certified (PACs), and advanced registered nurse practitioners (ARNPs) may provide inpatient hospital medical services to the client receiving CUP Women services. To bill MAA, use the Current Procedural Technology (CPT™) code from MAA's Physician-Related Services (RBRVS) Billing Instructions that most closely describes the service actually provided **(CPT codes 99221 through 99238, and/or 99431 and 99433)**.

Use the HCFA-1500 claim form when billing for physician/ARNP services.

Physicians and ARNPs may provide continuation of medical services to pregnant clients on an outpatient basis separate from the CUP Women Program. To bill MAA in this instance, use the CPT code from MAA's Physician-Related Services (RBRVS) Billing Instructions **(CPT codes 99201 through 99215)**, that most closely describes the service provided.

☞ **Note:** You **must** use both the primary and secondary ICD-9-CM diagnosis codes listed in **#2a and #2b on page E.1** when billing MAA for physician/ARNP services.

What is the time limit for billing? **[Refer to WAC 388-502-0150]**

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

  ✓ MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders MAA to cover the services; or

- ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria. MAA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:
  - ➢ DSHS certification of a client for a retroactive[2] period; or
  - ➢ The provider proves to MAA' s satisfaction that there are other extenuating circumstances.

- **Resubmitted Claims**

  Providers may **resubmit, modify**, **or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the designated time period listed above.

- The designated time periods do not apply to overpayments that the provider must refund to DSHS. After the designated time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument, such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:
  - ✓ The provider fails to meet these listed requirements; and
  - ✓ MAA does not pay the claim. **(See WAC 388-502-0160 for more information.)**

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

---

[1] **Delayed Certification** - According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf and then bill MAA for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month -If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not** bill, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification** -According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

How to Complete the UB-92 Claim Form

Only form locators that pertain to billing MAA are addressed below.

When submitting more than one page of the UB-92, be sure to fully complete the first page. Only the *detail lines* are picked up from the second page. Please clearly indicate Page 1 of 2, Page 2 of 2, etc., in the *Remarks* section (*form locator 84*).

If a client is not eligible for the entire hospital stay, bill only dates of service for which the client is eligible.

When billing electronically, indicate claim type "S" for RCC.

☞ **Note:** Shaded fields are required fields only for UB-92 Medicare/Medicaid Crossover Claims." **Medicare/Medicaid Crossover Claims cannot be billed electronically.**

FORM LOCATOR NAME AND INSTRUCTIONS FOR COMPLETION:

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with the MAA Division of Program Support (DPS).

3. **Patient Control No.** - This is a 20-digit alphanumeric entry **that you may use as your internal reference number**. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled *Patient Account Number*.

4. **Type of Bill** - Indicate type of bill using 3 digits as follows:

Type of Facility (first digit)
1 = Hospital
Bill Classification (second digit)
1 = Inpatient

Frequency (third digit)
1 = Admit through discharge claim
2 = Interim - First Claim
3 = Interim - Continuing Claim
4 = Interim - Last Claim
5 = Late Charge(s) Only Claim

6. **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on the client's Medical Identification card.

13. **Patient's Address** - Enter the client's address.

14. **Patient's Birthdate** - Enter the client's birthdate.

15. **Patient's Sex** - Enter the client's sex.

17. **Admission Date** - Enter the date of admission (MMDDYY).

18. **Admission Hour** - The hour during which the patient was admitted for inpatient care. Use the appropriate two-digit code listed in the next column.

Code	Time: A.M.	Code	Time: P.M.
00	12:00 - 12:59 (Midnight)	12	12:00 - 12:59 (Noon)
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	10:00 - 10:59	22	10:00 - 10:59
11	11:00 - 11:59	23	11:00 - 11:59

19. **Type of Admission** - Enter type of admission.

1 = Emergent
2 = Urgent
3 = Elective
4 = Newborn

20. **Source of Admission** - Enter source of admission.

1 = Physician Referral
2 = Clinic Referral
3 = HMO Referral
4 = Transfer from a hospital
5 = Transfer from a nursing facility
6 = Transfer from another health care facility
7 = Emergency Room
8 = Court/Law Enforcement
9 = Information Not Available

21. **Discharge Hour** - The hour during which the patient was discharged from care.

22. **Patient Status** - Enter one of the following codes to represent the disposition of the patient at discharge:

01 = Discharge to home or self care (routine discharge)
02 = Transferred to another short-term general hospital
03 = Discharged/transferred to nursing facility (SNF)
04 = Discharged/transferred to nursing facility (ICF)
05 = Transferred to an exempt unit or hospital
06 = Discharged/transferred to home under the care of an organized home health service organization
07 = Left against medical advice
08 = Discharged/transferred to home care of a Home IV provider
20 = Expired
30 = Still patient

Medicare Crossover claims only

39-41. Value Codes and Amounts - Enter one of the following, as appropriate:

45 = Accident Hour (use the chart listed next to form locator 18 for admission hours)

80 = Newborn's birth weight in gram

39A: **Deductible**: Enter the code *A1*, and the deductible as reported on your EOMB.

39D: **ENC Rate**: Enter Med's ENC rate as reported on the EOMB.

40A: **Coinsurance**: Enter the code *A2*, and the coinsurance as reported on your EOMB.

40D: **Encounter Units**: Enter the encounter units Medicare paid, as reported on EOMB.

41A: **Medicare Payment**: Enter the payment by Medicare as reported on your EOMB.

41D: **Medicare's Process Date**: Enter the date that Medicare processed the claim, as reported on your EOMB in numerals only (*MMDDYY*).

42. **Revenue Code** - Enter revenue code 129 for Room and Board Charges. For any other (ancillary) revenue codes, refer to MAA's Inpatient Billing Instructions.

43. **Revenue or Procedure Description** - Enter a narrative description of the related revenue included on this bill. Abbreviations may be used. Enter the description *total charges* on line 23 of this form locator on the final page.

44. **HCPCS/Rates** - Enter the accommodation rate for inpatient bills.

46. **Units of Service** - Enter the quantity of services listed by revenue or procedure code(s).

47. **Total Charges** - Enter charges pertaining to the related revenue code(s) or procedure code(s). Enter the total of this column as the last detail on line 23 of this form locator on the last page.

48. **Noncovered** - Any noncovered charges pertaining to detail revenue or procedure codes should be entered here. (These services will be *categorically denied*.) Enter the total of this column as the last detail on line 23 of this form locator on the last page.

50. **Payer Identification: A/B/C** - Enter if all health insurance benefits are available.

50A: Enter *Medicaid*.
50B: Enter the name of additional insurance (e.g., Medicare, Aetna, etc.), if applicable.
50C: Enter the name of additional insurance, if applicable.

51. **Provider Number** - Enter the hospital provider number issued to you by DPS. This is the seven-digit provider number beginning with a *3* that appears on your Remittance and Status Report.

Medicare Crossover claims only

51A: Enter the seven-digit Medicaid provider number that appears on your Remittance and Status Report.

51B: Enter your Medicare provider number.

54. **Prior Payments: A/B/C** - Enter the amount due or received from all insurances. **Do not include Spenddown or EMER here. See form locator 57.**

54A: Enter any prior payments from payor listed in form locator 50A.
54B: Enter any prior payments from payor listed in form locator 50B.
54C: Enter any prior payments from payor listed in form locator 50C.

55. **Estimated Amount Due: A/B/C** –

55A: Enter the estimated amount due from MAA minus any amounts listed in form locators 48, 54, and 57.
55B: Not required to be filled in.
55C: Not required to be filled in.

57. **Due from Patient (Patient Liability)** Enter the total patient liability amount which includes Spenddown and/or EMER.

☞ Refer to the bottom of the client's *Approval for MI EMER/Spenddown Met* Letter issued by the local DSHS Community Service Office for the Spenddown/EMER amount.

58. **Insured's Name: A/B/C** - If other insurance benefits are available and coverage is under another name, enter the insured's name.

60. **Cert-SSN-HIC-ID NO.** - Enter the Medicaid Patient (client) Identification Code (PIC) -an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Identification card. This information is obtained from the client's current monthly Medical Identification card and consists of the client's:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c. First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d. An alpha or numeric character (tie breaker).

61. **Insurance Group Name** - If other insurance benefits are available, enter the name of the group or the plan through which insurance is provided to the insured.

62. **Insurance Group Number** - If other insurance benefits are available, enter any identification number that identifies the group through which the individual is covered.

63. **Treatment Authorization** - Enter the assigned authorization number (be sure to enter all nine digits).

65. **Employer Name** - If other insurance benefits are available, enter the name of the employer that *might provide* or *does provide* health care coverage insurance for the individual.

67. **Principal Diagnosis Code** - Enter:

- 648.33 (drug dependency – antepartum);
- 648.34 (drug dependency – postpartum);
- 648.43 (for alcohol dependency – antepartum); or
- 648.44 (for alcohol dependency – postpartum).

68-75. **Other Diagnosis Codes** - Enter one of the following ICD-9-CM diagnosis codes:

- 304 - 304.93 (drug dependency); or
- 303 - 303.93 (alcohol dependency).

76. **Admitting Diagnosis -** Enter:

- 648.33 (drug dependency – antepartum);
- 648.34 (drug dependency – postpartum);
- 648.43 (for alcohol dependency – antepartum); or
- 648.44 (for alcohol dependency – postpartum).

80. **Principal Procedure Code** - The code that identifies the principal procedure performed during the period covered by this bill.

81 A-E **Other Procedure Codes** - The codes identifying all significant procedure(s) other than the principal procedure.

82. **Attending Physician I.D.** - Enter the seven-digit provider identification number of the attending physician. Do not complete this box with a clinic billing number. For attending physicians not enrolled in the Medical Assistance program, enter the name of the attending physician in this form locator.

83. **Other Physician I.D.** - Enter the referring provider number, or if unknown, enter the name of the provider who referred the client to services. If the client is under PCCM, you must use the referring PCCM provider number.

84. **Remarks** - Enter any information applicable to this stay that is not already indicated on the claim form such as extended stay approval.

Hospital Chemical Dependency
1111 Main St.
Anytown, WA 98000

3 PATIENT CONTROL NO: UB123456 | 4 TYPE OF BILL: 111

6 FED TAX NO | 5 STATEMENT COVERS PERIOD: FROM 10/01/02 THROUGH 10/20/02 | 7 DOW D | 8 N.C.D. | 9 C.C.D. | 10 L.R.D. | 11

2 PATIENT NAME: Mary Jane Smith

13 PATIENT ADDRESS: 1111 Market St. Anytown, WA 98000

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	CONDITION CODES 25	26	27	28	29	30	31
MM/DD/YYYY	F		10/01/02	09	2	2	10	01									

32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 A B C

	39 CODE	VALUE CODES AMOUNT		41 CODE	VALUE CODES AMOUNT
a					
b					
c					
d					

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
129	Daily Room, CUP	800.00		19	15200.00		
250	Pharmacy			10	300.00		
300	Laboratory			5	200.00		
001	Total Charges				15700.00		

SAMPLE

50 PAYER	51 PROVIDER NO	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicaid	3XXXXXX				15700.00	

57 — DUE FROM PATIENT

58 INSURED'S NAME	59 P REL	60 CERT. - SSN - HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Mary Jane Smith		MJ 999999 Smith A		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	68 CODE	69 CODE	OTHER DIAG. CODES		76 ADM. DIAG. CD.	77 E-CODE	78
.648.43	303.9				648.33		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID: 9999999 Dr. John Johnson

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X — 86 DATE

UB-92 HCFA-1450 — OCR/Original — -F.6-

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Hospital Chemical Dependency
1111 Main St.
Anytown, WA 98500

3 PATIENT CONTROL NO: UB123456
4 TYPE OF BILL: 111

6 STATEMENT COVERS PERIOD: 10/01/02 10/20/02

12 PATIENT NAME: Mary Jane Smith

13 PATIENT ADDRESS: 1111 Market St. Anytown, WA 98000

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO	CONDITION CODES
MM/DD/YYYY	F		10/01/02	09	2	2	10	01		

32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE SPAN FROM	THROUGH	35
							A B C

	39 CODE	39 VALUE CODES AMOUNT		41 CODE	41 VALUE CODES AMOUNT
a	A1	812.00			7500.00
b					
c					
d					

09/01/02

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
129	CUP, Dailey Room	800.00		19	15200.00		
250	Pharmacy			10	300.00		
300	Laboratory			5	200.00		
					15700.00		

SAMPLE CROSSOVER

50 PAYER	51 PROVIDER NO.	52 REL. INFO.	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicaid Medicare	3XXXXXX 5XXXXX			7500.00	812.00	

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P.REL	60 CERT. SSN HIC ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Mary Jane Smith Mary Jane Smith		999-99-9999 MJ 999999 Smith A		

63 TREATMENT AUTHORIZATION CODES	64 DCN	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CO	68	OTHER DIAG. CODES 69	70	71	72	73	74	75	76 ADM. DIAG. CD.	77 E CODE	78
648.43	303.9								648.33		

79 P.C.	80 PRINCIPAL PROCED. (I/C) CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE			OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID: 9999999 Dr. John Johnson

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X

86 DATE

UB-92 HCFA-1450 OCR/Original

CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

This is a blank page...